STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		155786	B. WING 05/02/2012				
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
			ALLISONVILLE RD				
ALLISONVILLE MEADOWS		5	FISHE	RS, IN 46038			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION		
PREFIX TAG		NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	Directive 17	DATE		
10000							
	A Life Safety C	ode Recertification and	K0000	The statements made in this	,		
	_	Survey was conducted by		plan of correction are not an			
		e Department of Health in		admission to and do not			
		1 42 CFR 483.70(a).		constitute an agreement with			
	accordance with	1 +2 C1 IC +03.70(a).		alledged deficiencies herein. remain in compliance with all	10		
	Survey Date: 0	5/02/12		federal and state regulations, Allisonville Meadows has take	en or		
	Facility Number	r: 012466		is planning to take the actions forth in the following plan of			
	Provider Number	er: 155786		correction. The plan of correction			
	AIM Number:	201014060		constitutes the homes allegat	ion		
				of compliance. All alleged deficiencies cited have been	or		
	Surveyor: Marl	k Caraher, Life Safety		are to be corrected by the dat			
	Code Specialist			dates indicated. May 31, 201			
		ety Code survey,					
	Allisonville Me	adows was found not in					
	compliance with	h Requirements for					
	Participation M	edicare/Medicaid, 42 CFR					
	Subpart 483.70(	(a), Life Safety From Fire					
	and the 2000 Ed	lition of the National Fire					
		ciation (NFPA) 101, Life					
	Safety Code (LS	SC), Chapter 18, New					
	Health Care Oc	cupancies and 410 IAC					
	16.2.						
	This one story f	acility was determined to					
	be of Type V (1	11) construction and fully					
	sprinklered. Th	e facility has a fire alarm					
	system with sm	oke detection in the					
	corridors, in are	as open to the corridors					
	and in all reside	ent rooms. The facility has					
	a capacity of 17	1 and had a census of 123					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155786	(X2) MULTIPLE CC A. BUILDING B. WING	01	COME	LETED 2/2012
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET A 10312 A	ADDRESS, CITY, STATE, ZIP O ALLISONVILLE RD RS, IN 46038	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) S VISIT.	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Quality Review by Code Specialist-Me The facility was	Robert Booher, Life Safety dical Surveyor on 05/04/12.  found not in compliance entioned regulatory				

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Event ID: FFN121

Facility ID: 012466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 01			COMPLETED	
		155786	B. WIN		<del></del>	05/02/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ALLISONVILLE RD		
ALLISONVILLE MEADOWS			FISHERS, IN 46038				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029	NFPA 101	ODE CTANDADD					
SS=E		ODE STANDARD s are protected in					
		8.4. The areas are enclosed					
		fire-rated barrier, with a 3/4					
		oor, without windows (in					
		8.4). Doors are self-closing					
	or automatic clos 7.2.1.8. 18.3.2	sing in accordance with 2.1					
	Based on observa	ation and interview, the	K00	)29	What corrective action will	be	05/31/2012
		ensure 4 of 15 doors			accomplished for those reside		
	serving hazardou	is areas such as fuel fired			found to have been affected by the deficient practice. No	У	
	heater rooms and	l storage rooms greater			residents were affected. The		
	than fifty square	feet in size used to store			central supply room, the dietar	-	
	combustible mate	erials are equipped with			storage room, the housekeepil office, and the mechanical roo	•	
	self closing device	ces on the doors. This			in the front lobby are now	111	
	deficient practice	e could affect any			equipped with self closing		
	resident, staff or	visitor in the vicinity of			devices. 2. How other resider		
	the Central Supp	ly storage room, the			having the potential to be affect		
	Dietary Storage I	Room in the 400 Hall, the			by the same deficient practice be identified and what correcti		
	Housekeeping O	ffice in the service			action will be taken. No reside	-	
	corridor and the	Mechanical Room in the			were affected. The central sup		
	front lobby.				room, the dietary storage room room, the housekeeping office		
					and the mechanical room in th		
	Findings include	:			front lobby are now equipped v	with	
					self closing devices. 3. What		
	Based on observa	ations with the			measures will be put in place of		
	Environmental S	upervisor during a tour			what systemic changes will be made to ensure that the deficie		
	of the facility fro	om 10:50 a.m. to 12:55			practice does not recur.		
	p.m. on 05/02/12	, the following areas'			Maintenance Supervisor has		
	_	not equipped with a self			been re-educated that these		
	closing device;	• • •			areas must have self closing		
	_	pply storage area			devices on the respective door identified above. 4. How the	S	
		uare feet and is used to			corrective actions will be		
	_	e supplies in cardboard			monitored to ensure the deficie	ent	
	Store Comoustion	- cappines in cardoourd			practice will not recur, what		

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Event ID: FFN121

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	ILDING	01	COMPLETED	
	155786		B. WIN			05/02/2012	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ALLISONVILLE RD		
ALLISONVILLE MEADOWS				RS, IN 46038			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	boxes including	undergarment			quality assurance program will	be	
	incontinence aid	ls and bandages,			put in place. The four doors		
	b. the Dietary S	torage Room in the 400			identified will be monitored we for 4 weeks by Enviormental	екіу	
	1	7 square feet and is used			Supervisor to ensure doors are	2	
		tible dietary supplies in			still self closing. the results of		
	cardboard boxes				audit will be submitted to the C		
		ping Office in the service			committee for further review a	nd	
					recommendations.		
		ed 264 square feet and is					
		mbustible comforters and					
	linens,						
		al Room in the front					
	lobby has one na	atural gas fired furnace in					
	the room.						
	Based on intervi	ew at the time of the					
	observations, the	e Environmental					
	Supervisor ackn	owledged each of the					
	_	areas' entry doors were					
		th a self closing device.					
	not equipped wi	un a sem closnig device.					
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPL	ETED
		155786	B. WIN			05/02/	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER		10312 ALLISONVILLE RD				
ALLISON	IVILLE MEADOWS			FISHEF	RS, IN 46038		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
K0050 SS=F	NFPA 101 LIFE SAFETY Consider Fire drills are hell varying condition shift. The staff is and is aware that routine. Responsion conducting drills competent person exercise leaders conducted between announcement in audible alarms.  Based on record facility failed to on the third shift for This deficient praces are identified as a staff and a season on the staff and the staff are incompeted as a season of the staff and the staff are incompeted as a season of the staff and the staff are incompeted as a season of the staff and the staff are incompeted as a staff are in	ODE STANDARD d at unexpected times under is, at least quarterly on each is familiar with procedures it drills are part of established sibility for planning and is assigned only to ons who are qualified to hip. Where drills are sen 9 PM and 6 AM a coded may be used instead of 18.7.1.2  review and interview, the document fire drills on in 1 of 4 calendar quarters. Sectice affects all indivisitors.  cof "Monthly Fire Drill intation with the upervisor from 9:10 a.m. 05/02/12, fire drill available for the third in quarter of 2011. Based the time of record review, all Supervisor redrill records for the fourth quarter of 2011	K00		1.What corrective actions will accomplished for those reside found to have been affected by the deficient practice. No residents were affected. The fulls will be conducted at unexpected times and varying conditions and a coded announcement will only be use between 10pm and 6am and documentation will accurately reflect all fire drills. 2. How oth residents having the potential be affected by the same deficipractice will be identified and what corrective action will be taken. No residents were affected. The fire drills will be conducted at unexpectant time and varying conditions and a coded announcement will only used from 10pm until 6am and documentation will accurately reflect all fire drills conducted. what measures will be put in place or what sytemic changes will be made to ensure that the deficient practice does not recomplete.	nts  y  ire  ed  er  to  ent  as  be  3.	05/31/2012
					Maintenance Supervisor has	uı.	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:  155786  A. BUILDING B. WING		COMPLETED 05/02/2012				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	(X5) COMPLETION DATE	
				been re-educated that the fire drills will be conducted accord to schedule at unexpected tim and varying conditions and a coded announcement will only used from 10p to 6am and documentation will accurately reflect all fire drills conducted. How the corrective action will I monitored to ensure the deficie practice will not recur, and what Quality assurance program will put into place to monitor. Fire alarm reports will be monitored monthly for 3 months by the Executive Director or designed ensure that the fire drills are conducted according to sched and unexpected times and varying conditions and a coder announcement is only used from 10pm to 6am and documentatic accurately reflects all fire drills conducted. The reults of the accurated for further review and recommendations.	es be 4. be ent at li be d eto ule d om ion udit		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786		LDING	ONSTRUCTION  01	(X3) DATE ( COMPL 05/02/	ETED
NAME OF PROVIDER OR SUPPLIER  ALLISONVILLE MEADOWS			_ <b>I</b>	10312 A	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0062 SS=F	Required automacontinuously main condition and are periodically. 18, 25, 9.7.5  Based on observer facility failed to pure supply of spare supply of spare sutomatic sprink with NFPA 25, 1 Standard for the Maintenance of Maintenance	ler system in accordance 998 Edition, the Inspection, Testing, and Water-Based Fire ms, Section 2-4.1.4 which of at least six spare e stored in a cabinet on replacement purposes. re sprinklers shall be presentative of the types ratings of the system nimum of two sprinklers temperature rating provided. This deficient fect all residents, staff e sprinkler system had to cause a proper sprinkler as a replacement.	K00	062	1. What corrective actions will accomplished for those reside found to have been affected be the same deficient practice. No residents were affected. We have come to install a sidewall sprinkler in the spare sprinkler cabinet for replacement purposes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No reside were affected. We have contacted our fire protection provider and they have come an installed a sidewall sprinkle the spare sprinkler cabinet for replacement purposes. 3. What measures will be put in place of what systemic changes will be made to ensure that the deficit practice does not recur. Maintenance Supervisor has been re-educated on the suppof at least six spare sprinklers shall be stored in a cabinet on premises for replacement purposes. the stock of spare sprinklers shall be proportional representitives of the types an tempertature rating of the sytes sprinklers. A minimum of two to the supports of the sytes sprinklers.	nts y lo ave out n v ents out er in at or e ent lly the lly d em	05/31/2012

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155786	A. BUILDING  B. WING	COMPLETED 05/02/2012
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATIO	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE
	sprinklers in the spare sprinkler cabinet, however, sidewall sprinkler heads were observed in the laundry room and throughout the facility. Based on interview at the time of observation, the lack of spare sidewall sprinklers in the spare sprinkler cabinet was acknowledged by the Environmental Supervisor.  3.1-19(b)	sprinklers of each type and temperature rating installed she provided. 4. How the corrective action will be monito ensure the deficient practic will not recur. What quality assurance programs will be place to monitor. The stock of spare sprinklers will be monitored weekly for 4 weeks and then monthly there after, to ensure that all sprinkler spares in the cabinet are present. The maintenance Supervisor will responsible for this monitoring. The results of the audit will be submitted to the CQI committed to th	ottored ce cout in cof cored ce cout in cored ce cored ce cored ce cored ce cored ce cored cored ce cored cored ce cored

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